We need this information to provide the best quality care. Your personal health information is kept private and secure, as required by federal and state privacy laws. If you have concerns, please leave blank and discuss with your GP. This form complies with the Royal Australian College of General Practitioners Standards for general practice.

PATIENT HEALTH SUMMARY

☐Mr ☐Ms ☐Mrs ☐Miss ☐Mast. ☐Dr ☐Other ____________________

Date Commenced

Record Number

SURNAME ______________________________

GIVEN NAMES ______________________________

DOB ____/____/____ GENDER ______________

COUNTRY of BIRTH ______________________ Are you of ABORIGINAL/TORRES STRAIT ISLANDER origin?: Y☐ N☐

ADDRESS	CHANGE of DETAILS
P/CODE	

PHONE: Home ____________ Mobile ____________ Work ____________

EMAIL ______________________ OCCUPATION ____________

NEXT OF KIN ____________ RELATIONSHIP ____________ PHONE ____________

EMERGENCY ____________ RELATIONSHIP ____________ PHONE ____________

MEDICARE ☐☐☐☐☐☐☐☐☐☐ EXP.DATE ____ REF ☐

HCC/PEN/DVA ☐☐☐☐☐☐☐☐☐☐ EXP.DATE ____

SIGNIFICANT FAMILY/SOCIAL HISTORY	ALLERGIES

HOW DID YOU HEAR ABOUT US? ☐FRIEND/RELATIVE ☐ GOOGLE ☐WEBSITE ☐SOCIAL MEDIA ☐LOCATION ☐ OTHER REFERAL ____________

PATIENT CONSENT: Our practice undertakes research, professional development, and quality assurance/improvement activities to improve patient care. All people accessing personal health information for this purpose have signed a written confidentiality agreement.

I consent to my health record being reviewed as part of the quality improvement activities at this practice. ☐Y ☐N

Our practice uses a reminder system to improve the quality of your health care. The practice sends reminders by mail or telephone for procedures such as vaccinations, Pap tests and other health reviews.

I consent to my referrals being securely sent electronically ☐Y ☐N

I consent to being contacted with reminders as part of the quality improvement activities at this practice. ☐Y ☐N

CONSENT FOR USE OF INFORMATION: I confirm that the information I have given (on this form) is correct. I consent to sharing of all relevant information between the general practitioners, specialists, nurse practitioners, nurses, allied health providers and non-clinical staff for the purpose of managing my health. I understand this information will be used to fulfil their duties in the course of planning and managing my health care.

Signature of patient or guardian______________________ Date______________________

☐I HAVE A MyHEALTH RECORD PLEASE DISCUSS UPLOAD OF YOUR HEALTH SUMMARY WITH YOUR DOCTOR OR NURSE

TRANSFER OF HEALTH INFORMATION: You may have consistently consulted with a GP at another practice. The health information held by that GP may assist us with your future health care needs. You may wish to have a copy or a summary of your health records transferred to this practice. Please ask the receptionist for information about how this can take place.